

103D CONGRESS
2D SESSION

S. 2122

To improve the public and private financing of long-term care and to strengthen the public safety net for elderly and non-elderly disabled individuals who lack adequate protection against long-term care expenses, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MAY 17 (legislative day, MAY 16), 1994

Mr. COHEN introduced the following bill; which was read the first time

A BILL

To improve the public and private financing of long-term care and to strengthen the public safety net for elderly and non-elderly disabled individuals who lack adequate protection against long-term care expenses, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-
2 tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) **SHORT TITLE.**—This Act may be cited as the
5 “Public/Private Long-Term Care Partnership Act of
6 1994”.

7 (b) **TABLE OF CONTENTS.**—The table of contents is
8 as follows:

Sec. 1. Short title; table of contents.

TITLE I—TAX TREATMENT OF LONG-TERM CARE INSURANCE

- Sec. 101. Qualified long-term care services treated as medical care.
- Sec. 102. Treatment of long-term care insurance.
- Sec. 103. Treatment of benefits under qualified long-term care policies.
- Sec. 104. Tax reserves for qualified long-term care insurance policies.
- Sec. 105. Tax treatment of accelerated death benefits under life insurance contracts.
- Sec. 106. Tax treatment of companies issuing qualified accelerated death benefit riders.

TITLE II—STANDARDS FOR LONG-TERM CARE INSURANCE

- Sec. 201. Policy requirements.
- Sec. 202. Additional requirements for issuers of long-term care insurance policies.
- Sec. 203. Coordination with State requirements.
- Sec. 204. Uniform language and definitions.
- Sec. 205. Effective dates.

TITLE III—INCENTIVES TO ENCOURAGE THE PURCHASE OF PRIVATE INSURANCE

- Sec. 301. Public information and education program.
- Sec. 302. Assets or resources disregarded under the medicaid program.
- Sec. 303. Distributions from individual retirement accounts for the purchase of long-term care insurance coverage.

TITLE IV—IMPROVED PUBLIC SAFETY NET FOR LONG-TERM CARE

- Sec. 401. References in title.
- Sec. 402. Spenddown eligibility for nursing facility residents.
- Sec. 403. Increase in personal needs allowance for institutionalized individuals.
- Sec. 404. Increased resource disregard for nursing facility residents.
- Sec. 405. Informing nursing home residents about availability of assistance for home and community-based services.
- Sec. 406. Establishment of State programs furnishing home and community-based services to certain individuals with disabilities.
- Sec. 407. Reports by the Secretary on certain issues relating to long-term care.
- Sec. 408. Report by the Secretary on long-term care services for chronically ill individuals.
- Sec. 409. Chronic Care Commission.
- Sec. 410. Demonstration projects on acute and long-term care integration.

1 **TITLE I—TAX TREATMENT OF**
2 **LONG-TERM CARE INSURANCE**

3 **SEC. 101. QUALIFIED LONG-TERM CARE SERVICES TREAT-**
4 **ED AS MEDICAL CARE.**

5 (a) GENERAL RULE.—Paragraph (1) of section
6 213(d) (defining medical care) is amended by striking
7 “or” at the end of subparagraph (B), by striking subpara-
8 graph (C), and by inserting after subparagraph (B) the
9 following new subparagraphs:

10 “(C) for qualified long-term care services
11 (as defined in subsection (f)),

12 “(D) for insurance covering medical care
13 referred to in—

14 “(i) subparagraphs (A) and (B), or

15 “(ii) subparagraph (C), but only if
16 such insurance is provided under a qualifi-
17 fied long-term care insurance policy (as de-
18 fined in section 7702B(b)) and the deduc-
19 tion under this section for amounts paid
20 for such insurance is not disallowed under
21 section 7702B(d)(4), or

22 “(E) for premiums under part B of title
23 XVIII of the Social Security Act, relating to
24 supplementary medical insurance for the aged.”

1 (b) QUALIFIED LONG-TERM CARE SERVICES DE-
2 FINED.—Section 213 (relating to the deduction for medi-
3 cal, dental, etc., expenses) is amended by adding at the
4 end the following new subsection:

5 “(f) QUALIFIED LONG-TERM CARE SERVICES.—For
6 purposes of this section—

7 “(1) IN GENERAL.—The term ‘qualified long-
8 term care services’ means necessary diagnostic, cur-
9 ing, mitigating, treating, preventive, therapeutic, and
10 rehabilitative services, and maintenance and per-
11 sonal care services (whether performed in a residen-
12 tial or nonresidential setting), which—

13 “(A) are required by an individual during
14 any period the individual is an incapacitated in-
15 dividual (as defined in paragraph (2)),

16 “(B) have as their primary purpose—

17 “(i) the provision of needed assistance
18 with 1 or more activities of daily living (as
19 defined in paragraph (3)), or

20 “(ii) protection from threats to health
21 and safety due to severe cognitive impair-
22 ment, and

23 “(C) are provided pursuant to a continuing
24 plan of care prescribed by a licensed profes-
25 sional (as defined in paragraph (4)).

1 “(2) INCAPACITATED INDIVIDUAL.—The term
2 ‘incapacitated individual’ means any individual who
3 has been certified by a licensed professional as—

4 “(A) being unable to perform, without sub-
5 stantial assistance from another individual, at
6 least 2 activities of daily living (as defined in
7 paragraph (3)),

8 “(B) having moderate cognitive impair-
9 ment as defined by the Secretary in consulta-
10 tion with the Secretary of Health and Human
11 Services, or

12 “(C) having a level of disability similar (as
13 determined by the Secretary in consulta-
14 tion with the Secretary of Health and Human Serv-
15 ices) to the level of disability described in sub-
16 paragraph (A).

17 “(3) ACTIVITIES OF DAILY LIVING.—Each of
18 the following is an activity of daily living:

19 “(A) Eating.

20 “(B) Toileting.

21 “(C) Transferring.

22 “(D) Bathing.

23 “(E) Dressing.

24 “(F) Continence.

25 “(4) LICENSED PROFESSIONAL.—

1 “(A) IN GENERAL.—The term ‘licensed
2 professional’ means—

3 “(i) a physician or registered profes-
4 sional nurse,

5 “(ii) a qualified community care case
6 manager (as defined in subparagraph (B)),
7 or

8 “(iii) any other individual who meets
9 such requirements as may be prescribed by
10 the Secretary after consultation with the
11 Secretary of Health and Human Services.

12 “(B) QUALIFIED COMMUNITY CARE CASE
13 MANAGER.—The term ‘qualified community
14 care case manager’ means an individual or en-
15 tity which—

16 “(i) has experience or has been
17 trained in providing case management
18 services and in preparing individual care
19 plans;

20 “(ii) has experience in assessing indi-
21 viduals to determine their functional and
22 cognitive impairment; and

23 “(iii) meets such requirements as may
24 be prescribed by the Secretary after con-

sultation with the Secretary of Health and Human Services.

“(5) CERTAIN SERVICES NOT INCLUDED.—The term ‘qualified long-term care services’ shall not include any services provided to an individual—

“(A) by a relative (directly or through a partnership, corporation, or other entity) unless the relative is a licensed professional with respect to such services, or

“(B) by a corporation or partnership which is related (within the meaning of section 267(b) or 707(b)) to the individual.

For purposes of this paragraph, the term ‘relative’ means an individual bearing a relationship to the individual which is described in paragraphs (1) through (8) of section 152(a).”.

17 (c) TECHNICAL AMENDMENTS.—Paragraph (6) of
18 section 213(d) is amended—

19 (1) by striking “subparagraphs (A) and (B)”
20 and inserting “subparagraphs (A), (B), and (C)”,
21 and

22 (2) by striking “paragraph (1)(C) applies” in
23 subparagraph (A) and inserting “subparagraphs (C)
24 and (D) of paragraph (1) apply”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1995.

4 SEC. 102. TREATMENT OF LONG-TERM CARE INSURANCE.

5 (a) GENERAL RULE.—Chapter 79 (relating to defin-
6 tions) is amended by inserting after section 7702A the fol-
7 lowing new section:

10 "(a) IN GENERAL.—For purposes of this title—

“(1) a qualified long-term care insurance policy (as defined in subsection (b)) shall be treated as an accident and health insurance contract.

14 “(2) any plan of an employer providing cov-
15 erage under a qualified long-term care insurance pol-
16 icy shall be treated as an accident and health plan
17 with respect to such coverage,

18 “(3) amounts (other than policyholder dividends
19 (as defined in section 808) or premium refunds) re-
20 ceived under a qualified long-term care insurance
21 policy (including nonreimbursement payments de-
22 scribed in subsection (b)(6)) shall be treated—

23 “(A) as amounts received for personal in-
24 juries and sickness, and

1 “(B) as amounts received for the permanent
2 loss of a function of the body and as amounts computed with reference to the nature
3 of injury under section 105(c) to the extent that such amounts do not exceed the dollar amount in effect under subsection (g) for the taxable year,

8 “(4) amounts paid for a qualified long-term care insurance policy described in subsection (b)(6) shall be treated as payments made for insurance for purposes of section 213(d)(1)(D), and

12 “(5) a qualified long-term care insurance policy shall be treated as a guaranteed renewable contract subject to the rules of section 816(e).

15 “(b) **QUALIFIED LONG-TERM CARE INSURANCE POLICY.**—For purposes of this title—

17 “(1) **IN GENERAL.**—The term ‘qualified long-term care insurance policy’ means any long-term care insurance policy that—

20 “(A) limits benefits under such policy to incapacitated individuals (as defined in section 213(f)(2)), and

23 “(B) satisfies the requirements of paragraphs (2), (3), (4), and (5).

1 “(2) PREMIUM REQUIREMENTS.—The require-
2 ments of this paragraph are met with respect to a
3 policy if such policy provides that premium pay-
4 ments may not be made earlier than the date such
5 payments would have been made if the policy pro-
6 vided for level annual payments over the life expect-
7 ancy of the insured or 20 years, whichever is short-
8 er. A policy shall not be treated as failing to meet
9 the requirements of the preceding sentence solely by
10 reason of a provision in the policy providing for a
11 waiver of premiums if the insured becomes an inca-
12 pacitated individual (as defined in section
13 219(f)(2)).

14 “(3) PROHIBITION OF CASH VALUE.—The re-
15 quirements of this paragraph are met if the policy
16 does not provide for a cash value or other money
17 that can be paid, assigned, pledged as collateral for
18 a loan, or borrowed, other than as provided in para-
19 graph (4).

20 “(4) REFUNDS OF PREMIUMS AND DIVI-
21 DENDS.—The requirements of this paragraph are
22 met with respect to a policy if such policy provides
23 that—

24 “(A) policyholder dividends are required to
25 be applied as a reduction in future premiums or

1 to increase benefits described in subsection
2 (a)(2),

3 “(B) refunds of premiums upon a partial
4 surrender or a partial cancellation are required
5 to be applied as a reduction in future pre-
6 miums, and

7 “(C) any refund on the death of the in-
8 sured, or on a complete surrender or cancella-
9 tion of the policy, cannot exceed the aggregate
10 premiums paid under the policy.

11 Any refund on a complete surrender or cancellation
12 of the policy shall be includable in gross income to
13 the extent that any deduction or exclusion was allow-
14 able with respect to the premiums.

15 “(5) COORDINATION WITH OTHER ENTITLE-
16 MENTS.—The requirements of this paragraph are
17 met with respect to a policy if such policy does not
18 cover expenses incurred to the extent that such ex-
19 penses are also covered under title XVIII of the So-
20 cial Security Act.

21 “(6) NONREIMBURSEMENT PAYMENTS PER-
22 MITTED.—For purposes of subsection (a)(4), a pol-
23 icy is described in this paragraph if, under the pol-
24 icy, payments are made to (or on behalf of) an in-
25 sured individual on a per diem or other periodic

1 basis without regard to the expenses incurred or
2 services rendered during the period to which the
3 payments relate.

4 **“(c) TREATMENT OF LONG-TERM CARE INSURANCE**
5 **POLICIES.**—For purposes of this title, any amount re-
6 ceived or coverage provided under a long-term care insur-
7 ance policy that is not a qualified long-term care insurance
8 policy shall not be treated as an amount received for per-
9 sonal injuries or sickness or provided under an accident
10 and health plan and shall not be treated as excludable
11 from gross income under any provision of this title.

12 **“(d) TREATMENT OF COVERAGE PROVIDED AS PART**
13 **OF A LIFE INSURANCE CONTRACT.**—Except as otherwise
14 provided in regulations, in the case of any long-term care
15 insurance coverage (whether or not qualified) provided by
16 rider on a life insurance contract, the following rules shall
17 apply:

18 **“(1) IN GENERAL.**—This section shall apply as
19 if the portion of the contract providing such cov-
20 erage is a separate contract or policy.

21 **“(2) PREMIUMS AND CHARGES FOR LONG-TERM**
22 **CARE COVERAGE.**—Premium payments for long-term
23 care insurance policy coverage and charges against
24 the life insurance contract’s cash surrender value
25 (within the meaning of section 7702(f)(2)(A)) for

1 such coverage, shall be treated as premiums for pur-
2 poses of subsection (b)(2).

3 “(3) APPLICATION OF 7702.—Section
4 7702(c)(2) (relating to the guideline premium limi-
5 tation) shall be applied by increasing, as of any date,
6 the guideline premium limitation with respect to a
7 life insurance contract by an amount equal to—

8 “(A) the sum of any charges (but not pre-
9 mium payments) described in paragraph (2)
10 made to that date under the contract, reduced
11 by

12 “(B) any such charges the imposition of
13 which reduces the premiums paid for the con-
14 tract (within the meaning of section
15 7702(f)(1)).

16 “(4) APPLICATION OF SECTION 213.—No deduc-
17 tion shall be allowed under section 213(a) for
18 charges against the life insurance contract's cash
19 surrender value described in paragraph (2), unless
20 such charges are includable in income as a result of
21 the application of section 72(e)(10) and the coverage
22 provided by the rider is a qualified long-term care
23 insurance policy under subsection (b).

24 For purposes of this subsection, the term ‘portion’ means
25 only the terms and benefits under a life insurance contract

1 that are in addition to the terms and benefits under the
2 contract without regard to the coverage under a long-term
3 care insurance policy.

4 **“(e) PROHIBITION OF DISCRIMINATION.—**

5 **“(1) IN GENERAL.—**Notwithstanding subsection
6 (a)(3), any plan of an employer providing coverage
7 under a qualified long-term care insurance policy
8 shall qualify as an accident and health plan with re-
9 spect to such coverage only if—

10 “(A) except as provided in paragraph (2),
11 the plan allows all employees to participate, and
12 **(B)** the benefits provided under the plan
13 are identical for all employees that choose to
14 participate.

15 **“(2) EXCLUSION OF CERTAIN EMPLOYEES.—**
16 For purposes of paragraph (1), there may be ex-
17 cluded from consideration—

18 “(A) employees who have not completed 3
19 years of service;

20 “(B) employees who have not attained age
21 25;

22 “(C) part-time or seasonal employees; and

23 “(D) employees who are nonresident aliens
24 and who receive no earned income (within the
25 meaning of section 911(d)(2)) from the em-

1 ployer which constitutes income from sources
2 within the United States (within the meaning of
3 section 861(a)(3)).

4 “(3) APPLICABILITY.—The provisions of this
5 subsection shall not apply to any plan of an em-
6 ployer providing coverage under a qualified long-
7 term care insurance policy until the Secretary of
8 Health and Human Services certifies to the Sec-
9 retary that provisions that are substantially similar
10 to the provisions of this subsection apply to all
11 health benefit plans.

12 “(f) EMPLOYER PLANS NOT TREATED AS DE-
13 FERRED COMPENSATION PLANS.—For purposes of this
14 title, a plan of an employer providing coverage under a
15 qualified long-term care insurance policy shall not be
16 treated as a plan which provides for deferred compensa-
17 tion by reason of providing such coverage.

18 “(g) DOLLAR AMOUNT FOR PURPOSES OF GROSS IN-
19 COME EXCLUSION.—

20 “(1) DOLLAR AMOUNT.—

21 “(A) IN GENERAL.—The dollar amount in
22 effect under this subsection shall be \$150 per
23 day.

24 “(B) INFLATION ADJUSTMENTS.—In the
25 case of any taxable year beginning in a calendar

1 year after 1996, the dollar amount contained in
2 subparagraph (A) shall be increased by an
3 amount equal to—

4 “(i) such dollar amount, multiplied by
5 “(ii) the cost-of-living adjustment de-
6 termined under section 1(f)(3) for the cal-
7 endar year in which the taxable year be-
8 gins, by substituting ‘calendar year 1995’
9 for ‘calendar year 1992’ in subparagraph
10 (B) thereof.

11 “(2) AGGREGATION RULE.—For purposes of
12 this subsection, all policies issued with respect to the
13 same taxpayer shall be treated as one policy.

14 “(h) REGULATIONS.—The Secretary shall prescribe
15 such regulations as may be necessary to carry out the re-
16 quirements of this section, including regulations to prevent
17 the avoidance of this section by providing long-term care
18 insurance coverage under a life insurance contract and to
19 provide for the proper allocation of amounts between the
20 long-term care and life insurance portions of a contract.”.

21 (b) CLERICAL AMENDMENT.—The table of sections
22 for chapter 79 is amended by inserting after the item re-
23 lating to section 7702A the following new item:

“Sec. 7702B. Treatment of long-term care insurance.”.

24 (c) EFFECTIVE DATE.—

1 (1) IN GENERAL.—The amendments made by
2 this section shall apply to policies issued after De-
3 cember 31, 1995. Solely for purposes of the preced-
4 ing sentence, a policy issued prior to January 1,
5 1996, that satisfies the requirements of a qualified
6 long-term care insurance policy as set forth in sec-
7 tion 7702B(b) shall, on and after January 1, 1996,
8 be treated as having been issued after December 31,
9 1995.

10 (2) TRANSITION RULE.—If, after the date of
11 enactment of this Act and before January 1, 1996,
12 a policy providing for long-term care insurance cov-
13 erage is exchanged solely for a qualified long-term
14 care insurance policy (as defined in section
15 7702B(b)), no gain or loss shall be recognized on
16 the exchange. If, in addition to a qualified long-term
17 care insurance policy, money or other property is re-
18 ceived in the exchange, then any gain shall be recog-
19 nized to the extent of the sum of the money and the
20 fair market value of the other property received. For
21 purposes of this paragraph, the cancellation of a pol-
22 icy providing for long-term care insurance coverage
23 and reinvestment of the cancellation proceeds in a
24 qualified long-term care insurance policy within 60
25 days thereafter shall be treated as an exchange.

9 SEC. 103. TREATMENT OF BENEFITS UNDER QUALIFIED
10 LONG-TERM CARE POLICIES.

11 (a) EXCLUSION FROM COBRA CONTINUATION RE-
12 QUIREMENTS.—Subparagraph (A) of section 4980B(f)(2)
13 of the Internal Revenue Code of 1986 (defining continu-
14 ation coverage) is amended by adding at the end the fol-
15 lowing new sentence: “The coverage shall not include cov-
16 erage for qualified long-term care services (as defined in
17 section 213(f)).”.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to taxable years beginning after
3 December 31, 1995.

4 SEC. 104. TAX RESERVES FOR QUALIFIED LONG-TERM
5 CARE INSURANCE POLICIES.

6 (a) IN GENERAL.—Subparagraph (A) of section
7 807(d)(3) of the Internal Revenue Code of 1986 (relating
8 to tax reserve methods) is amended by redesignating
9 clause (iv) as clause (v) and by inserting after clause (iii)
10 the following new clause:

11 “(iv) QUALIFIED LONG-TERM CARE
12 INSURANCE POLICIES.—In the case of any
13 qualified long-term care insurance policy
14 (as defined in section 7702B(b))—

15 “(I) the reserve method pre-
16 scribed by the National Association of
17 Insurance Commissioners which cov-
18 ers such policy (as of the date of issu-
19 ance); or

20 “(II) if no reserve method has
21 been prescribed by the National Asso-
22 ciation of Insurance Commissioners
23 which covers such policy, a 1-year full
24 preliminary term method.”.

1 (b) CONFORMING AMENDMENT.—Clause (v) of sec-
2 tion 807(d)(3)(A) of the Internal Revenue Code of 1986
3 (relating to tax reserve methods) is amended in the matter
4 preceding subclause (I) by striking “(ii) or (iii)” and in-
5 serting “(ii), (iii), or (iv)”.

6 (c) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 1995.

9 SEC. 105. TAX TREATMENT OF ACCELERATED DEATH BENE-
10 FITS UNDER LIFE INSURANCE CONTRACTS.

11 (a) GENERAL RULE.—Section 101 (relating to cer-
12 tain death benefits) is amended by adding at the end the
13 following new subsection:

14 "(g) TREATMENT OF CERTAIN ACCELERATED
15 DEATH BENEFITS.—

16 “(1) IN GENERAL.—For purposes of this sec-
17 tion, any amount distributed to an individual under
18 a life insurance contract on the life of an insured
19 who is a terminally ill individual (as defined in para-
20 graph (3)) shall be treated as an amount paid by
21 reason of the death of such insured.

22 " (2) NECESSARY CONDITIONS.—

23 “(A) Paragraph (1) shall not apply to any
24 distribution unless—

1 “(i) the distribution is not less than
2 the present value (determined under sub-
3 paragraph (B)) of the reduction in the
4 death benefit otherwise payable in the
5 event of the death of the insured, and

6 “(ii) the percentage derived by divid-
7 ing the cash surrender value of the con-
8 tract, if any, immediately after the dis-
9 tribution by the cash surrender value of
10 the contract immediately before the dis-
11 tribution is equal to or greater than the
12 percentage derived by dividing the death
13 benefit immediately after the distribution
14 by the death benefit immediately before the
15 distribution.

16 “(B) The present value of the reduction in
17 the death benefit occurring by reason of the dis-
18 tribution shall be determined by—

19 “(i) using as the discount rate a rate
20 not in excess of the highest rate set forth
21 in subparagraph (C), and

22 “(ii) assuming that the death benefit
23 (or the portion thereof) would have been
24 paid at the end of a period that is no more
25 than the insured's life expectancy from the

1 date of the distribution or 12 months,
2 whichever is shorter.

3 “(C) RATES.—The rates set forth in this
4 subparagraph are the following:

5 “(i) the 90-day Treasury bill yield,

6 “(ii) the rate described as Moody's
7 Corporate Bond Yield Average-Monthly
8 Average Corporates as published by
9 Moody's Investors Service, Inc., or any
10 successor thereto, for the calendar month
11 ending 2 months before the date on which
12 the rate is determined,

13 “(iii) the rate used to compute the
14 cash surrender values under the contract
15 during the applicable period plus 1 percent
16 per annum, and

17 “(iv) the maximum permissible inter-
18 est rate applicable to policy loans under
19 the contract.

20 “(3) TERMINALLY ILL INDIVIDUAL.—For pur-
21 poses of this subsection, the term ‘terminally ill indi-
22 vidual’ means an individual who, as determined by
23 the insurer on the basis of an acceptable certifi-
24 cation by a licensed physician, has an illness or
25 physical condition which can reasonably be expected

1 to result in death within 12 months of the date of
2 certification.

3 “(4) APPLICATION OF SECTION 72(e)(10).—For
4 purposes of section 72(e)(10) (relating to the treat-
5 ment of modified endowment contracts), section
6 72(e)(4)(A)(i) shall not apply to distributions de-
7 scribed in paragraph (1).”.

8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) shall apply to taxable years beginning after
10 December 31, 1995.

11 SEC. 106. TAX TREATMENT OF COMPANIES ISSUING QUALI-
12 FIED ACCELERATED DEATH BENEFIT RID-
13 ERS.

14 (a) QUALIFIED ACCELERATED DEATH BENEFIT RID-
15 ERS TREATED AS LIFE INSURANCE.—Section 818 (relat-
16 ing to other definitions and special rules) is amended by
17 adding at the end the following new subsection:

18 "(g) QUALIFIED ACCELERATED DEATH BENEFIT
19 RIDERS TREATED AS LIFE INSURANCE.—For purposes of
20 this part—

21 “(1) IN GENERAL.—Any reference to a life in-
22 surance contract shall be treated as including a ref-
23 erence to a qualified accelerated death benefit rider
24 on such contract.

1 “(2) QUALIFIED ACCELERATED DEATH BENE-
2 FIT RIDERS.—For purposes of this subsection, the
3 term ‘qualified accelerated death benefit rider’
4 means any rider on a life insurance contract which
5 provides for a distribution to an individual upon the
6 insured becoming a terminally ill individual (as de-
7 fined in section 101(g)(3)).”.

8 (b) DEFINITIONS OF LIFE INSURANCE AND MODI-
9 FIED ENDOWMENT CONTRACTS.—Paragraph (5)(A) of
10 section 7702(f) is amended by striking “or” at the end
11 of clause (iv), by redesignating clause (v) as clause (vi),
12 and by inserting after clause (iv) the following new clause:

13 “(v) any qualified accelerated death
14 benefit rider (as defined in section 818(g)),
15 or”.

16 (c) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The amendments made by
18 this section shall apply to contracts issued after
19 December 31, 1995.

20 (2) TRANSITIONAL RULE.—For purposes of de-
21 termining whether section 7702 or 7702A of the In-
22 ternal Revenue Code of 1986 applies to any con-
23 tract, the issuance, whether before, on, or after De-
24 cember 31, 1995, of a rider on a life insurance con-
25 tract permitting the acceleration of death benefits

1 (as described in section 101(g) of such Code) shall
2 not be treated as a modification or material change
3 of such contract.

4 **TITLE II—STANDARDS FOR**
5 **LONG-TERM CARE INSURANCE**

6 **SEC. 201. POLICY REQUIREMENTS.**

7 (a) APPLICATION OF CONSUMER PROTECTION PRO-
8 VISIONS TO QUALIFIED POLICIES.—Section
9 7702B(b)(1)(B) (as added by section 102) is amended by
10 inserting “and of subsection (f)” after “and (5)”.

11 (b) CONSUMER PROTECTION PROVISIONS.—Section
12 7702B (as added by section 102) is amended by redesign-
13 ning subsection (f) as subsection (h) and by inserting
14 after subsection (e) the following new subsections:

15 “(f) CONSUMER PROTECTION PROVISIONS.—

16 “(1) IN GENERAL.—The requirements of this
17 subsection are met with respect to any long-term
18 care insurance policy if the policy meets—

19 “(A) the requirements of the model regula-
20 tion and model Act described in paragraph (2),

21 “(B) the disclosure requirement of para-
22 graph (3),

23 “(C) the requirements relating to
24 nonforfeitability under paragraph (4), and

1 “(D) the requirements relating to rate sta-
2 bilization under paragraph (5).

3 “(2) REQUIREMENTS OF MODEL REGULATION
4 AND ACT.—

5 “(A) IN GENERAL.—The requirements of
6 this paragraph are met with respect to any
7 long-term care insurance policy if such policy
8 meets—

9 “(i) MODEL REGULATION.—The fol-
10 lowing requirements of the model regula-
11 tion:

12 “(I) Section 7A (relating to guar-
13 anteed renewal or noncancellability),
14 and the requirements of section 6B of
15 the model Act relating to such section
16 7A.

17 “(II) Section 7B (relating to pro-
18 hibitions on limitations and exclu-
19 sions).

20 “(III) Section 7C (relating to ex-
21 tension of benefits).

22 “(IV) Section 7D (relating to
23 continuation or conversion of cov-
24 erage).

1 “(V) Section 7E (relating to dis-
2 continuance and replacement of poli-
3 cies).

4 “(VI) Section 8 (relating to unin-
5 tentional lapse).

6 “(VII) Section 9 (relating to dis-
7 closure), other than section 9F there-
8 of.

9 “(VIII) Section 10 (relating to
10 prohibitions against post-claims un-
11 derwriting).

12 “(IX) Section 11 (relating to
13 minimum standards).

14 “(X) Section 12 (relating to re-
15 quirement to offer inflation protec-
16 tion), except that any requirement for
17 a signature on a rejection of inflation
18 protection shall permit the signature
19 to be on an application or on a sepa-
20 rate form.

21 “(XI) Section 23 (relating to pro-
22 hibition against preexisting conditions
23 and probationary periods in replace-
24 ment policies or certificates).

1 “(ii) MODEL ACT.—The following re-
2 quirements of the model Act:

3 “(I) Section 6C (relating to pre-
4 existing conditions).

5 “(II) Section 6D (relating to
6 prior hospitalization).

7 “(B) DEFINITIONS.—For purposes of this
8 paragraph—

9 “(i) MODEL PROVISIONS.—The terms
10 ‘model regulation’ and ‘model Act’ mean
11 the long-term care insurance model regula-
12 tion, and the long-term care insurance
13 model Act, respectively, promulgated by
14 the National Association of Insurance
15 Commissioners (as adopted in January of
16 1993).

17 “(ii) COORDINATION.—Any provision
18 of the model regulation or model Act listed
19 under clause (i) or (ii) of subparagraph
20 (A) shall be treated as including any other
21 provision of such regulation or Act nec-
22 essary to implement the provision.

23 “(3) TAX DISCLOSURE REQUIREMENT.—The re-
24 quirement of this paragraph is met with respect to

1 any long-term care insurance policy if such policy
2 meets the requirements of section 4980C(d)(1).

3 **“(4) NONFORFEITURE REQUIREMENTS.—**

4 **“(A) IN GENERAL.—**The requirements of
5 this paragraph are met with respect to any
6 long-term care insurance policy, if the issuer of
7 such policy offers to the policyholder, including
8 any group policyholder, a nonforfeiture provi-
9 sion.

10 **“(B) REQUIREMENTS OF PROVISION.—**The
11 nonforfeiture provision required under subpara-
12 graph (A) shall meet the following require-
13 ments:

14 “(i) The nonforfeiture provision shall
15 be appropriately captioned.

16 “(ii) The nonforfeiture provision shall
17 provide for a benefit available in the event
18 of a default in the payment of any pre-
19 miums and the amount of the benefit may
20 be adjusted subsequent to being initially
21 granted only as necessary to reflect
22 changes in claims, persistency, and interest
23 as reflected in changes in rates for pre-
24 mium paying policies approved by the Sec-
25 retary for the same policy form.

1 “(iii) The nonforfeiture provision shall
2 provide at least one of the following:

3 “(I) Reduced paid-up insurance.

4 “(II) Extended term insurance.

5 “(III) Shortened benefit period.

6 “(IV) Other similar offerings ap-
7 proved by the Secretary.

8 “(5) RATE STABILIZATION.—

9 “(A) IN GENERAL.—The requirements of
10 this paragraph are met with respect to any
11 long-term care insurance policy, including any
12 group master policy, if—

13 “(i) such policy contains the minimum
14 rate guarantees specified in subparagraph
15 (B), and

16 “(ii) the issuer of such policy meets
17 the requirements specified in subparagraph
18 (C).

19 “(B) MINIMUM RATE GUARANTEES.—The
20 minimum rate guarantees specified in this sub-
21 paragraph are as follows:

22 “(i) Rates under the policy shall be
23 guaranteed for a period of at least 3 years
24 from the date of issue of the policy.

1 “(ii) After the expiration of the 3-year
2 period required under clause (i), any rate
3 increase shall be guaranteed for a period of
4 at least 2 years from the effective date of
5 such rate increase.

6 “(iii) In the case of any individual age
7 75 or older who has maintained coverage
8 under a long-term care insurance policy for
9 10 years, rate increases under such policy
10 shall not exceed 10 percent in any 12-
11 month period.

12 “(C) INCREASES IN PREMIUMS.—The re-
13 quirements specified in this subparagraph are
14 as follows:

15 “(i) IN GENERAL.—If an issuer of any
16 long-term care insurance policy, including
17 any group master policy, plans to increase
18 the premium rates for a policy, such issuer
19 shall, at least 90 days before the effective
20 date of the rate increase, offer to each in-
21 dividual policyholder under such policy the
22 option to remain insured under the policy
23 at a reduced level of benefits which main-
24 tains the premium rate at the rate in effect

1 on the day before the effective date of the
2 rate increase.

3 “(ii) INCREASES OF MORE THAN 50
4 PERCENT.—If an issuer of any long-term
5 care insurance policy, including any group
6 master policy, increases premium rates for
7 a policy by more than 50 percent in any 3-
8 year period—

9 “(I) in the case of a group mas-
10 ter long-term care insurance policy,
11 the issuer shall discontinue issuing all
12 group master long-term care insur-
13 ance policies in any State in which the
14 issuer issues such policy for a period
15 of 2 years from the effective date of
16 such premium increase; and

17 “(II) in the case of an individual
18 long-term care insurance policy, the
19 issuer shall discontinue issuing all in-
20 dividual long-term care policies in any
21 State in which the issuer issues such
22 policy for a period of 2 years from the
23 effective date of such premium in-
24 crease.

1 This clause shall apply to any issuer of
2 long-term care insurance policies or any
3 other person that purchases or otherwise
4 acquires any long-term care insurance poli-
5 cies from another issuer or person.

6 “(D) MODIFICATIONS OR WAIVERS OF RE-
7 QUIREMENTS.—The Secretary may modify or
8 waive any of the requirements under this para-
9 graph if—

10 “(i) such requirements will adversely
11 affect an issuer’s solvency;

12 “(ii) such modification or waiver is re-
13 quired for the issuer to meet other State or
14 Federal requirements;

15 “(iii) medical developments, new dis-
16 abling diseases, changes in long-term care
17 delivery, or a new method of financing
18 long-term care will result in changes to
19 mortality and morbidity patterns or as-
20 sumptions;

21 “(iv) judicial interpretation of a pol-
22 icy’s benefit features results in unintended
23 claim liabilities; or

24 “(v) in the case of a purchase or other
25 acquisition of long-term care insurance

1 policies of an issuer or other person, the
2 continued sale of other long-term care in-
3 surance policies by the purchasing issuer
4 or person is in the best interests of individ-
5 ual consumers.

6 “(g) LONG-TERM CARE INSURANCE POLICY DE-
7 FINED.—

8 “(1) IN GENERAL.—For purposes of this sec-
9 tion, the term ‘long-term care insurance policy’
10 means any product which is advertised, marketed, or
11 offered as long-term care insurance (as defined in
12 paragraph (2)).

13 “(2) LONG-TERM CARE INSURANCE.—

14 “(A) IN GENERAL.—The term ‘long-term
15 care insurance’ means any insurance policy or
16 rider—

17 “(i) advertised, marketed, offered, or
18 designed to provide coverage for not less
19 than 12 consecutive months for each cov-
20 ered person on an expense incurred, in-
21 demnity, prepaid or other basis for one or
22 more necessary or medically necessary di-
23 agnostic, preventive, therapeutic, rehabili-
24 tative, maintenance, or personal care serv-

1 ices provided in a setting other than an
2 acute care unit of a hospital; and

3 “(ii) issued by insurers, fraternal ben-
4 efit societies, nonprofit health, hospital,
5 and medical service corporations, prepaid
6 health plans, health maintenance organiza-
7 tions or any similar organization to the ex-
8 tent such organizations are otherwise au-
9 thorized to issue life or health insurance.

10 Such term includes group and individual annu-
11 ties and life insurance policies or riders which
12 provide directly or which supplement long-term
13 care insurance and includes a policy or rider
14 which provides for payment of benefits based on
15 cognitive impairment or the loss of functional
16 capacity.

17 “(B) EXCLUSIONS.—The term ‘long-term
18 care insurance’ shall not include—

19 “(i) any insurance policy which is of-
20 fered primarily to provide basic coverage to
21 supplement coverage under the medicare
22 program under title XVIII of the Social
23 Security Act, basic hospital expense cov-
24 erage, basic medical-surgical expense cov-
25 erage, hospital confinement coverage,

1 major medical expense coverage, disability
2 income or related asset-protection cov-
3 erage, accident only coverage, specified dis-
4 ease or specified accident coverage, or lim-
5 ited benefit health coverage; or
6 “(ii) life insurance policies—
7 “(I) which accelerate the death
8 benefit specifically for one or more of
9 the qualifying events of terminal ill-
10 ness or medical conditions requiring
11 extraordinary medical intervention or
12 permanent institutional confinement;
13 “(II) which provide the option of
14 a lump-sum payment for such bene-
15 fits; and
16 “(III) under which neither such
17 benefits nor the eligibility for the ben-
18 efits is conditioned upon the receipt of
19 long-term care.”.

20 **SEC. 202. ADDITIONAL REQUIREMENTS FOR ISSUERS OF**
21 **LONG-TERM CARE INSURANCE POLICIES.**

22 (a) IN GENERAL.—Chapter 43 is amended by adding
23 at the end the following new section:

1 "SEC. 4980C. FAILURE TO MEET REQUIREMENTS FOR LONG-
2 TERM CARE INSURANCE POLICIES.

3 "(a) GENERAL RULE.—There is hereby imposed on
4 the issuer of any long-term care insurance policy with re-
5 spect to which any requirement of subsection (c) or (d)
6 is not met a tax in the amount determined under sub-
7 section (b).

8 "(b) AMOUNT OF TAX.—

9 "(1) IN GENERAL.—The amount of the tax im-
10 posed by subsection (a) shall be \$100 per policy for
11 each day any requirement of subsection (c) or (d) is
12 not met with respect to the policy.

13 "(2) WAIVER.—In the case of a failure which is
14 due to reasonable cause and not to willful neglect,
15 the Secretary may waive part or all of the tax im-
16 posed by subsection (a) to the extent that payment
17 of the tax would be excessive relative to the failure
18 involved.

19 "(c) ADDITIONAL RESPONSIBILITIES.—The require-
20 ments of this subsection with respect to any long-term
21 care insurance policy are as follows:

22 "(1) REQUIREMENTS OF MODEL PROVISIONS.—

23 "(A) MODEL REGULATION.—The following
24 requirements of the model regulation must be
25 met:

1 “(i) Section 13 (relating to application
2 forms and replacement coverage).

3 “(ii) Section 14 (relating to reporting
4 requirements), except that the issuer shall
5 also report at least annually the number of
6 claims denied during the reporting period
7 for each class of business (expended as a
8 percentage of claims denied), other than
9 claims denied for failure to meet the wait-
10 ing period or because of any applicable
11 pre-existing condition.

12 “(iii) Section 20 (relating to filing re-
13 quirements for marketing).

14 “(iv) Section 21 (relating to standards
15 for marketing), including inaccurate com-
16 pletion of medical histories, other than sec-
17 tion 21C(1) and 21C(6) thereof, except
18 that—

19 “(I) in addition to such require-
20 ments, no person shall, in selling or
21 offering to sell a long-term care insur-
22 ance policy, misrepresent a material
23 fact; and

24 “(II) no such requirements shall
25 include a requirement to inquire or

1 identify whether a prospective applicant or enrollee for long-term care insurance has accident and sickness insurance.

5 “(v) Section 22 (relating to appropriateness of recommended purchase).

7 “(vi) Section 24 (relating to standard format outline of coverage).

9 “(vii) Section 25 (relating to requirement to deliver shopper's guide).

11 “(B) MODEL ACT.—The following requirements of the model Act must be met:

13 “(i) Section 6F (relating to right to return), except that such section shall also apply to denials of applications and any refund shall be made within 30 days of the return or denial.

18 “(ii) Section 6G (relating to outline of coverage).

20 “(iii) Section 6H (relating to requirements for certificates under group plans).

22 “(iv) Section 6I (relating to policy summary).

24 “(v) Section 6J (relating to monthly reports on accelerated death benefits).

1 “(vi) Section 7 (relating to incontest-
2 ability period).

3 “(C) DEFINITIONS.—For purposes of this
4 paragraph, the terms ‘model regulation’ and
5 ‘model Act’ have the meanings given such terms
6 by section 7702B(f)(2)(B).

7 “(2) DELIVERY OF POLICY.—If an application
8 for a long-term care insurance policy (or for a cer-
9 tificate under a group long-term care insurance pol-
10 icy) is approved, the issuer shall deliver to the appli-
11 cant (or policyholder or certificate-holder) the policy
12 (or certificate) of insurance not later than 30 days
13 after the date of the approval.

14 “(3) INFORMATION ON DENIALS OF CLAIMS.—
15 If a claim under a long-term care insurance policy
16 is denied, the issuer shall, within 60 days of the date
17 of a written request by the policyholder or certifi-
18 cate-holder (or representative)—

19 “(A) provide a written explanation of the
20 reasons for the denial, and

21 “(B) make available all information di-
22 rectly relating to such denial.

23 “(d) DISCLOSURE.—The requirements of this sub-
24 section are met with respect to any long-term care insur-
25 ance policy if either of the following statements, whichever

1 is applicable, is prominently displayed on the front page
2 of the policy and in the outline of coverage required under
3 subsection (c)(1)(B)(ii):

4 “(1) A statement that: ‘This policy is intended
5 to be a qualified long-term care insurance contract
6 under section 7702B(b) of the Internal Revenue
7 Code of 1986.’.

8 “(2) A statement that: ‘This policy is not in-
9 tended to be a qualified long-term care insurance
10 contract under section 7702B(b) of the Internal
11 Revenue Code of 1986.’.

12 “(e) LONG-TERM CARE INSURANCE POLICY DE-
13 FINED.—

14 “(1) IN GENERAL.—For purposes of this sec-
15 tion, the term ‘long-term care insurance policy’
16 means any product which is advertised, marketed, or
17 offered as long-term care insurance (as defined in
18 paragraph (2)).

19 “(2) LONG-TERM CARE INSURANCE.—

20 “(A) IN GENERAL.—The term ‘long-term
21 care insurance’ means any insurance policy or
22 rider—

23 “(i) advertised, marketed, offered, or
24 designed to provide coverage for not less
25 than 12 consecutive months for each cov-

1 ered person on an expense incurred, in-
2 demnity, prepaid or other basis for one or
3 more necessary or medically necessary di-
4 agnostic, preventive, therapeutic, rehabili-
5 tative, maintenance, or personal care serv-
6 ices provided in a setting other than an
7 acute care unit of a hospital; and

8 “(ii) issued by insurers, fraternal ben-
9 efit societies, nonprofit health, hospital,
10 and medical service corporations, prepaid
11 health plans, health maintenance organiza-
12 tions or any similar organization to the ex-
13 tent such organizations are otherwise au-
14 thorized to issue life or health insurance.

15 Such term includes group and individual annu-
16 ties and life insurance policies or riders which
17 provide directly or which supplement long-term
18 care insurance and includes a policy or rider
19 which provides for payment of benefits based on
20 cognitive impairment or the loss of functional
21 capacity.

22 “(B) EXCLUSIONS.—The term ‘long-term
23 care insurance’ shall not include—

24 “(i) any insurance policy which is of-
25 fered primarily to provide basic coverage to

1 supplement coverage under the medicare
2 program under title XVIII of the Social
3 Security Act, basic hospital expense cov-
4 erage, basic medical-surgical expense cov-
5 erage, hospital confinement coverage,
6 major medical expense coverage, disability
7 income or related asset-protection cov-
8 erage, accident only coverage, specified dis-
9 ease or specified accident coverage, or lim-
10 ited benefit health coverage; or

11 “(ii) life insurance policies—

12 “(I) which accelerate the death
13 benefit specifically for one or more of
14 the qualifying events of terminal ill-
15 ness or medical conditions requiring
16 extraordinary medical intervention or
17 permanent institutional confinement;

18 “(II) which provide the option of
19 a lump-sum payment for such bene-
20 fits; and

21 “(III) under which neither such
22 benefits nor the eligibility for the ben-
23 efits is conditioned upon the receipt of
24 long-term care.”.

1 (b) CONFORMING AMENDMENT.—The table of sec-
2 tions for chapter 43 is amended by adding at the end the
3 following new item:

“Sec. 4980C. Failure to meet requirements for long-term care in-
surance policies.”.

4 **SEC. 203. COORDINATION WITH STATE REQUIREMENTS.**

5 Nothing in this subtitle shall be construed as prevent-
6 ing a State from applying standards that provide greater
7 protection of policyholders of long-term care insurance
8 policies (as defined in section 7702B(g) of the Internal
9 Revenue Code of 1986).

10 **SEC. 204. UNIFORM LANGUAGE AND DEFINITIONS.**

11 (a) IN GENERAL.—The National Association of In-
12 surance Commissioners shall not later than January 1,
13 1995, promulgate standards for the use of uniform lan-
14 guage and definitions in long-term care insurance policies
15 (as defined in section 7702B(g) of the Internal Revenue
16 Code of 1986).

17 (b) VARIATIONS.—Standards under subsection (a)
18 may permit the use of nonuniform language to the extent
19 required to take into account differences among States in
20 the licensing of nursing facilities and other providers of
21 long-term care.

1 **SEC. 205. EFFECTIVE DATES.**

2 (a) SECTION 201.—The amendments made by section
3 201 shall apply to contracts issued after December 31,
4 1995.

5 (b) SECTION 202.—The amendments made by sec-
6 tion 202 shall apply to actions taken after December 31,
7 1995.

8 **TITLE III—INCENTIVES TO EN-
9 COURAGE THE PURCHASE OF
10 PRIVATE INSURANCE**

11 **SEC. 301. PUBLIC INFORMATION AND EDUCATION PRO-
12 GRAM.**

13 (a) IN GENERAL.—The Secretary of Health and
14 Human Services shall establish a program designed to
15 educate individuals regarding—

16 (1) the risk of incurring catastrophic long-term
17 care costs;

18 (2) the coverage or lack of coverage of such
19 costs through Federal programs;

20 (3) the importance of planning for such costs;
21 and

22 (4) the benefits of securing long-term care in-
23 surance coverage.

24 (b) AUTHORIZATION OF APPROPRIATIONS.—There
25 are authorized to be appropriated such sums as may be
26 necessary to carry out the purposes of this section.

1 SEC. 302. ASSETS OR RESOURCES DISREGARDED UNDER
2 THE MEDICAID PROGRAM.

3 (a) MEDICAID ESTATE RECOVERIES.—

4 (1) IN GENERAL.—Section 1917(b) of the So-
5 cial Security Act (42 U.S.C. 1396p(b)) is
6 amended—

7 (A) in paragraph (1), by striking subparagraph (C);

9 (B) in paragraph (3), by striking “(other
10 than paragraph (1)(C))”; and

11 (C) in paragraph (4)(B), by striking “(and
12 shall include, in the case of an individual to
13 whom paragraph (1)(C)(i) applies)”.

14 (2) EFFECTIVE DATE.—Section 1917(b) of the
15 Social Security Act (42 U.S.C. 1396p(b)) shall be
16 applied and administered as if the provisions strick-
17 en by paragraph (1) had not been enacted.

18 (b) REPORTING REQUIREMENTS FOR CERTAIN
19 ASSET PROTECTION PROGRAMS.—Section 1902 of the So-
20 cial Security Act (42 U.S.C. 1396a) is amended by adding
21 at the end the following new subsection:

22 “(aa)(1) The Secretary shall not approve any State
23 plan amendment providing for an asset protection pro-
24 gram (as described in paragraph (2)) unless the State re-
25 quires all insurers participating in such program to submit
26 reports to the State and the Secretary at such times, and

1 containing such information, as the Secretary determines
2 appropriate. The information included in the reports re-
3 quired to be submitted under the preceding sentence shall
4 be submitted in accordance with the data standards estab-
5 lished by the Secretary under paragraph (3).

6 “(2) An asset protection program described in this
7 paragraph is a program under which an individual’s assets
8 and resources are disregarded for purposes of the program
9 under this title—

10 “(A) to the extent that payments are made
11 under a long-term care insurance policy; or

12 “(B) because an individual has received (or is
13 entitled to receive) benefits under a long-term care
14 insurance policy.

15 “(3)(A) Not later than 30 days after the date of the
16 enactment of this Act, the Secretary shall select data
17 standards for the information required to be included in
18 reports submitted in accordance with paragraph (1). Such
19 data standards shall be selected from the data standards
20 included in the Long-term Care Insurance Uniform Data
21 Set developed by the University of Maryland Center on
22 Aging and Laguna Research Associates, and used by the
23 States of California, Connecticut, Indiana, and New York
24 for reports submitted by insurers under the asset protec-
25 tion programs conducted by such States.

1 “(B) The Secretary shall modify the standards se-
2 lected under subparagraph (A) as the Secretary deter-
3 mines appropriate.”.

4 SEC. 303. DISTRIBUTIONS FROM INDIVIDUAL RETIREMENT
5 ACCOUNTS FOR THE PURCHASE OF LONG-
6 TERM CARE INSURANCE COVERAGE.

7 (a) EXCLUSION FROM GROSS INCOME FOR CERTAIN
8 INDIVIDUALS.—Subsection (d) of section 408 of the Inter-
9 national Revenue Code of 1986 (relating to tax treatment of
10 distributions from individual retirement accounts) is
11 amended by adding at the end the following new para-
12 graph:

13 “(8) DISTRIBUTIONS TO PURCHASE LONG-TERM
14 CARE INSURANCE.—

15 “(A) IN GENERAL.—Paragraph (1) shall
16 not apply to the applicable percentage of any
17 amount paid or distributed out of an individual
18 retirement account or individual retirement an-
19 nuity to the individual for whose benefit the ac-
20 count or annuity is maintained if—

21 “(i) the individual has attained age
22 59½ by the date of the payment or dis-
23 tribution; and

1 used within 90 days to purchase a qual-
2 fied long-term care insurance policy (as de-
3 fined in section 7702B(b)) for the benefit
4 of the individual or the spouse of the indi-
5 vidual (if the spouse has attained age 59½
6 by the date of the payment or distribu-
7 tion).

8 “(B) APPLICABLE PERCENTAGE.—For
9 purposes of subparagraph (A), the term ‘appli-
10 cable percentage’ means 100 percent reduced
11 (but not below zero) by the number of percent-
12 age points determined by dividing—

13 “(i) the amount by which the tax-
14 payer’s adjusted gross income exceeds the
15 minimum amount, by

16 “(ii) the difference between the maxi-
17 mum amount and the minimum amount.

18 “(C) MINIMUM AND MAXIMUM
19 AMOUNTS.—

20 “(i) IN GENERAL.—For purposes of
21 subparagraph (B), the minimum amount is
22 \$45,000 and the maximum amount is
23 \$100,000.

24 “(ii) COST-OF-LIVING ADJUSTMENT.—
25 In the case of any taxable year beginning

1 in any calendar year after 1996, each of
2 the dollar amounts under clause (i) shall
3 be increased by an amount equal to—

4 “(I) the dollar amount, multi-
5 plied by

6 “(II) the cost-of-living adjust-
7 ment determined under section 1(f)(3)
8 for the calendar year in which the tax-
9 able year begins, by substituting ‘cal-
10 endar year 1995’ for ‘calendar year
11 1992’ in subparagraph (B) thereof.

12 “(iii) ROUNDING.—If any amount de-
13 termined under clause (ii) is not a multiple
14 of \$10, the amount shall be rounded to the
15 nearest multiple of \$10 (or if the amount
16 is a multiple of \$5 and not a multiple of
17 \$10, the amount shall be increased to the
18 next multiple of \$10).

19 “(iv) SPECIAL RULE.—In the case of
20 a married individual filing a separate re-
21 turn, the minimum and maximum amounts
22 with respect to such individual shall be 50
23 percent of the amounts otherwise in effect
24 for the taxable year.”.

25 (b) NO PENALTY FOR DISTRIBUTIONS.—

1 (1) IN GENERAL.—Subparagraph (B) of section
2 72(t)(2) of the Internal Revenue Code of 1986 (re-
3 lating to distributions from qualified retirement
4 plans not subject to 10 percent additional tax) is
5 amended to read as follows:

6 “(B) MEDICAL EXPENSES.—

7 “(i) IN GENERAL.—Distributions
8 made to the employee (other than distribu-
9 tions described in clause (ii) or subpara-
10 graph (A) or (C)) to the extent such dis-
11 tributions do not exceed the amount allow-
12 able as a deduction under section 213 to
13 the employee for amounts paid during the
14 taxable year for medical care (determined
15 without regard to whether the employee
16 itemizes deductions for such taxable year).

17 “(ii) CERTAIN DISTRIBUTIONS TO
18 PURCHASE LONG-TERM CARE INSUR-
19 ANCE.—Distributions made to the taxpayer
20 out of an individual retirement plan if the
21 entire amount received (including money
22 and any other property) is used within 90
23 days to purchase a qualified long-term care
24 insurance policy (as defined in section

1 7702B(b)) for the benefit of the individual
2 or the spouse of the individual.”.

3 (2) CONFORMING AMENDMENT.—Subparagraph
4 (A) of section 72(t)(3) of the Internal Revenue Code
5 of 1986 is amended by striking “(B)” and inserting
6 “(B)(i)”.

7 (c) DEDUCTION FOR EXPENSES TO PURCHASE A
8 QUALIFIED LONG-TERM CARE INSURANCE POLICY.—

9 (1) IN GENERAL.—Paragraph (8) of section
10 408(d) of the Internal Revenue Code of 1986 (relat-
11 ing to distributions from individual retirement ac-
12 counts to purchase long-term care insurance), as
13 added by subsection (a), is amended by adding at
14 the end the following new subparagraph:

15 “(D) APPLICATION OF SECTION 213.—No
16 deduction shall be allowed under section 213(a)
17 for expenses incurred to purchase a qualified
18 long-term care insurance policy (as defined in
19 section 7702B(b)) using amounts paid or dis-
20 tributed out of an individual retirement account
21 or individual retirement annuity in accordance
22 with this paragraph.”.

23 (2) CONFORMING AMENDMENT.—Clause (ii) of
24 section 213(d)(1)(D) of the Internal Revenue Code
25 of 1986 (relating to definition of medical care), as

1 added by section 101(a), is amended by striking
2 “section 7702(d)(4)” and inserting “section
3 408(d)(8)(D) or section 7702(d)(4)”.
4

5 (d) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to taxable years beginning after
7 December 31, 1995.

8 **TITLE IV—IMPROVED PUBLIC
9 SAFETY NET FOR LONG-TERM
CARE**

10 **SEC. 401. REFERENCES IN TITLE.**

11 Except as otherwise specifically provided, whenever in
12 this title an amendment is expressed in terms of an
13 amendment to or repeal of a section or other provision,
14 the reference shall be considered to be made to that sec-
15 tion or other provision of the Social Security Act.

16 **SEC. 402. SPENDDOWN ELIGIBILITY FOR NURSING FACIL-
17 ITY RESIDENTS.**

18 (a) IN GENERAL.—Section 1902(a)(10)(A)(i) (42
19 U.S.C. 1396a(a)(10)(A)(i)) is amended—

20 (1) by striking “or” at the end of subclause
21 (VI);

22 (2) by striking the semicolon at the end of
23 subclause (VII) and inserting “, or”; and

24 (3) by inserting after subclause (VII) the fol-
25 lowing new subclause:

1 “(VIII) who are individuals who
2 would meet the income and resource
3 requirements of the appropriate State
4 plan described in subclause (I) or the
5 supplemental security income program
6 (as the case may be), if incurred ex-
7 penses for medical care as recognized
8 under State law were deducted from
9 income;”.

10 (b) LIMITATION TO BENEFITS FOR NURSING FACIL-
11 ITY SERVICES.—Section 1902(a)(10) (42 U.S.C.
12 1396a(a)(10)) is amended in the matter following sub-
13 paragraph (F)—

14 (1) by striking “and (XIII)” and inserting
15 “(XIII)”; and

16 (2) by inserting before the semicolon at the end
17 the following: “, and (XIV) the medical assistance
18 made available to an individual described in sub-
19 paragraph (A)(i)(VIII) shall be limited to medical
20 assistance for nursing facility services”.

21 (c) EFFECTIVE DATE.—The amendments made by
22 subsections (a) and (b) shall apply with respect to a State
23 as of January 1, 1996.

1 SEC. 403. INCREASE IN PERSONAL NEEDS ALLOWANCE FOR
2 INSTITUTIONALIZED INDIVIDUALS.

3 (a) IN GENERAL.—Section 1902(q)(2) (42 U.S.C.
4 1396a(q)(2)) is amended—

5 (1) by striking “\$30” and inserting “\$50”; and
6 (2) by striking “\$60” and inserting “\$80”.

7 (b) FEDERAL REIMBURSEMENT FOR REDUCTIONS IN
8 STATE FUNDS ATTRIBUTABLE TO INCREASED PERSONAL
9 NEEDS ALLOWANCE.—Section 1903(a) (42 U.S.C.
10 1396b(a)) is amended—

11 (1) by striking “plus” at the end of paragraph
12 (6);

13 (2) by striking the period at the end of para-
14 graph (7) and inserting “; plus”; and

15 (3) by adding at the end the following new
16 paragraph:

17 “(8) an amount equal to 100 percent of the dif-
18 ference between the amount of expenditures made by
19 the State for nursing facility services and services in
20 an intermediate care facility for the mentally re-
21 retarded during the quarter and the amount of ex-
22 penditures that would have been made by the State
23 for such services during the quarter based on the
24 personal needs allowance in effect in the State under
25 section 1902(q) as of April 30, 1994.”

1 (c) CONFORMING SSI PERSONAL NEEDS ALLOW-
2 ANCE.—Section 1611(e)(1)(B) (42 U.S.C. 1382(e)(1)(B))
3 is amended—

4 (1) in clauses (i) and (ii)(I), by striking “\$360”
5 and inserting “\$600”; and
6 (2) in clause (iii), by striking “\$720” and in-
7 serting “\$1,200”.

8 (d) EFFECTIVE DATE.—The amendments made by
9 subsection (a) shall apply with respect to months begin-
10 ning with January 1996.

11 **SEC. 404. INCREASED RESOURCE DISREGARD FOR NURS-**
12 **ING FACILITY RESIDENTS.**

13 (a) INCREASED DISREGARD FOR RESOURCES.—Sec-
14 tion 1902(a) (42 U.S.C. 1396a(a)) is amended—

15 (1) by striking “and” at the end of paragraph
16 (61);

17 (2) by striking the period at the end of para-
18 graph (62) and inserting “; and”; and

19 (3) by inserting after paragraph (62) the fol-
20 lowing new paragraph:

21 “(63) provide that, in determining the eligibility
22 of any unmarried individual who is an inpatient in
23 a nursing facility or intermediate care facility for the
24 mentally retarded, the first \$8,000 of resources may,
25 at the option of the State, be disregarded;”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply with respect to months begin-
3 ning with January 1996.

4 **SEC. 405. INFORMING NURSING HOME RESIDENTS ABOUT**
5 **AVAILABILITY OF ASSISTANCE FOR HOME**
6 **AND COMMUNITY-BASED SERVICES.**

7 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
8 1396a(a)), as amended by section 404(a), is amended—
9 (1) by striking “and” at the end of paragraph
10 (62);

11 (2) by striking the period at the end of para-
12 graph (63) and inserting “; and”; and
13 (3) by inserting after paragraph (63) the fol-
14 lowing new paragraph:

15 “(64) provide that an individual who is a resi-
16 dent (or who is applying to become a resident) of a
17 nursing facility or intermediate care facility for the
18 mentally retarded (or a designated representative of
19 such an individual) shall receive, at the time of ap-
20 plication for medical assistance and periodically
21 thereafter, information on the range of home and
22 community-based services for which assistance is
23 available in the State either under the plan under
24 this title or any other public program.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to quarters beginning on or after
3 January 1, 1996.

4 **SEC. 406. ESTABLISHMENT OF STATE PROGRAMS FURNISH-**
5 **ING HOME AND COMMUNITY-BASED SERV-**
6 **ICES TO CERTAIN INDIVIDUALS WITH DIS-**
7 **ABILITIES.**

8 (a) STATE PLAN REQUIREMENT.—Section 1902(a)
9 (42 U.S.C. 1396a(a)), as amended by sections 404(a) and
10 405(a), is amended—

11 (1) by striking “and” at the end of paragraph
12 (63);

13 (2) by striking the period at the end of para-
14 graph (64) and inserting “; and”; and

15 (3) by adding at the end the following new
16 paragraph:

17 “(65) at the option of the State, provide for the
18 establishment of a program under which the State
19 furnishes covered home and community-based serv-
20 ices (as defined in section 1931(c)(1)) to eligible in-
21 dividuals with disabilities (as defined in section
22 1931(c)(2)) in accordance with section 1931.”.

23 (b) ESTABLISHMENT OF PROGRAM.—Title XIX (42
24 U.S.C. 1936 et seq.) is amended by redesignating section

1 1931 as section 1932 and by inserting after section 1930
2 the following new section:

3 **“HOME AND COMMUNITY-BASED SERVICES FOR**
4 **INDIVIDUALS WITH DISABILITIES**

5 **“SEC. 1931. (a) ESTABLISHMENT OF PROGRAM.—**
6 Each State with an approved State plan under this title
7 may establish a program under which the State furnishes
8 covered home and community-based services to eligible in-
9 dividuals with disabilities in accordance with this section
10 to the extent that such services are not provided under
11 any other Federal or State program.

12 **“(b) ASSESSMENTS.—**

13 **“(1) INITIAL ASSESSMENT.—**A State program
14 under this section shall provide for an initial assess-
15 ment of all individuals who appear to have a reason-
16 able likelihood of being an eligible individual with
17 disabilities. Such an assessment may be conducted
18 by a qualified case manager or by any other person
19 or entity designated by the State under criteria spec-
20 ified by the Secretary.

21 **“(2) INITIAL ASSESSMENT DESCRIBED.—**

22 **“(A) IN GENERAL.—**Except as provided in
23 subparagraph (B), an initial assessment under
24 this paragraph shall be conducted using a uni-
25 form protocol specified by the Secretary and
26 shall include an assessment of an individual’s—

1 “(i) ability or inability to perform any
2 activities of daily living;
3 “(ii) health status;
4 “(iii) mental status;
5 “(iv) current living arrangement; and
6 “(v) use of formal and informal long-
7 term care support systems.

8 “(B) EXCEPTION.—If a State receives ad-
9 vance approval from the Secretary, such State
10 may—

11 “(i) conduct an initial assessment
12 under this paragraph using a protocol
13 other than a uniform protocol specified by
14 the Secretary under subparagraph (A); and
15 “(ii) collect information in addition to
16 the information required under clauses (i)
17 through (v) of subparagraph (A).

18 “(3) PERIODIC REASSESSMENT.—A State pro-
19 gram under this section shall provide for periodic re-
20 assessments of any eligible individual with disabil-
21 ties who is receiving covered home and community-
22 based services under this section. Such periodic reas-
23 sessments shall be conducted upon any significant
24 change in an individual’s condition that may affect
25 the individual’s need for such services, but at least

1 within the 6-month period following each assessment
2 of the individual (or within such longer period as de-
3 termined appropriate by the State in the case of an
4 individual who is unlikely to have a change in condi-
5 tion that would affect the individual's need for serv-
6 ices).

7 **“(c) QUALIFIED CASE MANAGER.—**

8 **“(1) IN GENERAL.—**A State program under
9 this section shall assign a qualified case manager to
10 any eligible individual with disabilities receiving cov-
11 ered home and community-based services under this
12 section. Such qualified case manager shall perform
13 the case management services specified in this sub-
14 subsection.

15 **“(2) CARE PLAN.—**A qualified case manager
16 shall develop, or arrange for the development of, an
17 individualized written plan of care for an eligible in-
18 dividual with disabilities based upon the assessments
19 conducted under subsection (b). The qualified case
20 manager shall develop the care plan in a timely
21 manner in consultation with the individual or the in-
22 dividual's representative, the individual's family, and
23 the individual's primary medical care provider, and
24 in accordance with any criteria that may be specified

1 by the State, in consultation with the Secretary. At
2 a minimum, the care plan shall identify—

3 “(A) the long-term problems and needs of
4 the individual;

5 “(B) the mix of formal and informal serv-
6 ices and support systems that are available to
7 meet the long-term care needs of the individual;

8 “(C) the appropriate covered home and
9 community-based services necessary to meet the
10 long-term care needs of the individual;

11 “(D) the manner in which covered home
12 and community-based services will be provided;

13 “(E) the manner in which covered home
14 and community-based services will be integrated
15 with services provided under any other Federal
16 or State program; and

17 “(F) goals for the individual which, to the
18 extent practicable, shall include goals that are
19 measurable.

20 “(3) REVISIONS TO CARE PLAN.—A qualified
21 case manager shall revise an individual's care plan
22 as appropriate based on the assessments performed
23 under subsection (b).

24 “(4) STATE GUIDELINES WITH RESPECT TO
25 CARE PLANS.—

1 “(A) TAKING INTO ACCOUNT INFORMAL
2 CARE.—A State may, at its option, provide
3 guidelines permitting a qualified case manager
4 to take into account the availability of informal
5 care in determining the amount and array of
6 covered home and community-based services
7 made available to an eligible individual with dis-
8 abilities under such individual’s care plan.

9 “(B) COORDINATION.—A State shall pro-
10 vide guidelines for qualified case managers to
11 integrate covered home and community-based
12 services with other Federal and State programs
13 in accordance with paragraph (2)(E).

14 “(5) PROVISION OF SERVICES.—

15 “(A) COVERED SERVICES.—The qualified
16 case manager, in consultation with an eligible
17 individual with disabilities or the individual’s
18 representative, such individual’s family, and
19 such individual’s primary medical care provider,
20 shall—

21 “(i) assist in the implementation of
22 the care plan; and

23 “(ii) in a manner that is cost-effective
24 and consistent with obtaining quality care,
25 provide, or arrange for the provision of,

1 appropriate covered home and community-
2 based services.

3 To the extent possible, the case manager shall
4 comply with the choice of an individual with
5 disabilities regarding which covered home and
6 community-based services to receive and the
7 providers who will furnish such services.

8 “(B) NONCOVERED SERVICES.—The State
9 may require the qualified case manager to as-
10 sist an eligible individual with disabilities in ob-
11 taining noncovered services, at the individual’s
12 own expense or through other programs that
13 may be available.

14 “(6) CARE PLAN MONITORING.—The qualified
15 case manager shall monitor the delivery of services
16 to an eligible individual with disabilities, the quality
17 of care provided, and the status of the individual.

18 “(d) QUALITY ASSURANCE AND SAFEGUARDS.—

19 “(1) QUALITY ASSURANCE.—A State shall en-
20 sure and monitor the quality of covered home and
21 community-based services furnished to eligible indi-
22 viduals with disabilities by—

23 “(A) adopting standards which safeguard
24 the health and safety of such individuals;

1 “(B) establishing minimum standards for
2 qualified case managers and providers and en-
3 forcing those standards;

4 “(C) establishing minimum competency re-
5 quirements for employees of qualified providers
6 and developing systems for enforcing such com-
7 petency requirements;

8 “(D) obtaining meaningful input from eli-
9 gible individuals with disabilities through sur-
10 veys or otherwise that measure the extent to
11 which such individuals receive the covered home
12 and community-based services described in the
13 care plan and the extent to which such individ-
14 uals are satisfied with such services;

15 “(E) participating in quality assurance ac-
16 tivities; and

17 “(F) specifying the role of the State Long-
18 Term Care Ombudsman (under the Older
19 Americans Act of 1965) and the protection and
20 advocacy system (established under section 142
21 of the Developmental Disabilities Assistance
22 and Bill of Rights Act) of the State in assuring
23 quality of services and protecting the rights of
24 individuals with disabilities.

25 “(2) SAFEGUARDS.—

1 “(A) CONFIDENTIALITY.—The State shall
2 provide safeguards which restrict the use or dis-
3 closure of information concerning individuals
4 applying for or receiving covered home and
5 community-based services under this section to
6 purposes directly connected with the adminis-
7 tration of the program.

8 “(B) SAFEGUARDS AGAINST ABUSE.—The
9 State shall provide safeguards against physical,
10 emotional, or financial abuse or exploitation in
11 the provision of case management services and
12 covered home and community-based services.

13 “(e) INDIVIDUAL CHOICE.—The acceptance of bene-
14 fits under this section is a voluntary choice of the eligible
15 individual with disabilities or the individual’s representa-
16 tive. Nothing in this section shall be construed to require
17 such an individual to accept the services available under
18 this section, or to accept benefits under this section in-
19 stead of entering a nursing facility or intermediate care
20 facility for the mentally retarded. An eligible individual
21 with disabilities shall not be denied covered home and com-
22 munity-based services under this section solely because the
23 individual refuses to accept one such service, unless the
24 failure to accept such service would make other services

1 ineffective or no alternative is available that is cost-effic-
2 tive and acceptable to the individual.

3 **“(f) PAYMENT METHODS.—**

4 **“(1) IN GENERAL.—**A State shall specify the
5 payment methods and rates to be used to reimburse
6 qualified providers and qualified case managers for
7 services furnished under the State's program under
8 this section. Methods of payment specified by the
9 State may include reimbursement on a fee-for-serv-
10 ice basis, prepayment on a capitation basis, or a
11 combination of such methods. Payment rates speci-
12 fied by the State shall be sufficient to ensure that
13 the requirements of section 1902(a)(30)(A) are sat-
14 isfied. The State, at its option, may permit qualified
15 case managers to negotiate rates with qualified pro-
16 viders.

17 **“(2) PAYMENT IN FULL.—**The State shall re-
18 strict payment for covered home and community-
19 based services to qualified providers who agree to ac-
20 cept the payment rates specified by the State under
21 paragraph (1) as payment in full for such services.

22 **“(3) COST SHARING.—**A State may impose
23 nominal cost sharing charges for covered home and
24 community-based services furnished to eligible indi-
25 viduals with disabilities whose family income (as de-

1 terminated in accordance with section 1902(l)(3)(E))
2 exceeds 100 percent of the income official poverty
3 line (as defined by the Office of Management and
4 Budget, and revised annually in accordance with sec-
5 tion 673(2) of the Omnibus Budget Reconciliation
6 Act of 1981) applicable to a family of the size in-
7 volved.

8 “(g) MAINTENANCE OF EFFORT.—A State program
9 under this section must provide assurances that, in the
10 case of an individual receiving medical assistance for home
11 and community-based services under this title as of the
12 date of the enactment of this section, the State will con-
13 tinue to make available (either under this title or other-
14 wise) to such individual an appropriate level of assistance
15 for home and community-based services, taking into ac-
16 count the level of assistance provided as of such date and
17 the individual’s need for home and community-based
18 services.

19 “(h) DEFINITIONS.—For purposes of this section—
20 “(1) COVERED HOME AND COMMUNITY-BASED
21 SERVICES.—

22 “(A) IN GENERAL.—The term ‘covered
23 home and community-based services’ means
24 case management services and other services

1 furnished by a qualified provider, including the
2 following:

3 "“(i) Personal assistance services.

4 "“(ii) Homemaker and chore assist-
5 ance.

6 "“(iii) Respite services.

7 "“(iv) Assistive devices.

8 "“(v) Adult day services.

9 "“(vi) Habilitation and rehabilitation.

10 "“(vii) Skilled home health care serv-
11 ices.

12 "“(B) EXCLUSIONS AND LIMITATIONS.—

13 The term 'covered home and community-based
14 services' shall not include—

15 "“(i) room and board;

16 "“(ii) services furnished in a hospital,
17 nursing facility, intermediate care facility
18 for the mentally retarded, or other institu-
19 tional care setting, as specified by the Sec-
20 retary;

21 "“(iii) items or services covered under
22 a private insurance policy; or

23 "“(iv) any services specified in a care
24 plan which are not specified in subpara-
25 graph (A).

1 “(C) PERSONAL ASSISTANCE SERVICES.—

2 The term ‘personal assistance services’ means
3 services specified by the State as personal as-
4 sistance services, and shall include at least
5 hands-on and standby assistance, supervision,
6 and cueing with activities of daily living.

7 “(2) ELIGIBLE INDIVIDUAL WITH DISABIL-
8 ITIES.—

9 “(A) IN GENERAL.—The term ‘eligible in-
10 dividual with disabilities’ means an individual
11 with disabilities—

12 “(i)(I) whose family income (as deter-
13 mined in accordance with section
14 1902(l)(3)(E)) does not exceed the phase-
15 in eligibility percentage (specified in sub-
16 paragraph (C)) of the income official pov-
17 erty line (as defined by the Office of Man-
18 agement and Budget, and revised annually
19 in accordance with section 673(2) of the
20 Omnibus Budget Reconciliation Act of
21 1981) applicable to a family of the size in-
22 volved; and

23 “(II) whose resources (other than re-
24 sources excluded pursuant to section 1613
25 (a) and (b)) are not more than \$8,000 (or,

1 for a couple, the amount determined under
2 section 1924 with respect to the spouses of
3 institutionalized individuals); or

4 “(ii) who would meet the income and
5 resource requirements under clause (i) if
6 incurred expenses for services described in
7 clauses (i) through (vii) of paragraph
8 (1)(A) were deducted from income.

9 “(B) INDIVIDUALS EXCLUDED.—Notwith-
10 standing subparagraph (A), no individual with
11 disabilities shall be an eligible individual with
12 disabilities for purposes of this section if—

13 “(i) such individual is eligible for serv-
14 ices in a nursing facility or an intermediate
15 care facility for the mentally retarded; and

16 “(ii) a qualified case manager esti-
17 mates (under methods specified by the Sec-
18 retary) that the cost of furnishing covered
19 home and community-based services to the
20 individual under this section would be
21 higher than the cost of institutionalizing
22 the individual.

23 “(C) PHASE-IN ELIGIBILITY PERCENT-
24 AGE.—For purposes of subparagraph (A), the

1 phase-in eligibility percentage for a calendar
2 year shall be—

3 “(i) for calendar year 1997, 90 per-
4 cent;

5 “(ii) for calendar year 1998, 110 per-
6 cent;

7 “(iii) for calendar year 1999, 130 per-
8 cent; and

9 “(iv) for calendar year 2000 and suc-
10 ceeding calendar years, 150 percent.

11 “(3) INDIVIDUAL WITH DISABILITIES.—

12 “(A) IN GENERAL.—The term ‘individual
13 with disabilities’ means any individual who is
14 described in any of the following categories of
15 individuals:

16 “(i) INDIVIDUALS REQUIRING HELP
17 WITH ACTIVITIES OF DAILY LIVING.—An
18 individual of any age who—

19 “(I) requires hands-on or standby
20 assistance, supervision, or cueing (as
21 defined in regulations) to perform two
22 or more activities of daily living (as
23 defined in subparagraph (B)); and

1 “(II) is expected to require such
2 assistance, supervision, or cueing over
3 a period of at least 100 days.

4 “(ii) INDIVIDUALS WITH MODERATE
5 COGNITIVE OR MENTAL IMPAIRMENT.—An
6 individual of any age—

7 “(I) whose score, on any stand-
8 ard mental status protocol appropriate
9 for measuring the individual's particu-
10 lar condition, as specified by the Sec-
11 retary, indicates either moderate cog-
12 nitive impairment or moderate mental
13 impairment, or both;

14 “(II) who displays symptoms of
15 one or more serious behavioral prob-
16 lems, contained on a list of such prob-
17 lems specified by the Secretary, that
18 create a need for supervision to pre-
19 vent harm to the individual or others;
20 and

21 “(III) who is expected to meet
22 the conditions of clause (i) or (ii) over
23 a period of at least 100 days.

24 “(iii) INDIVIDUALS WITH SEVERE OR
25 PROFOUND MENTAL RETARDATION.—An

1 individual of any age who has severe or
2 profound mental retardation (as deter-
3 mined according to a protocol specified by
4 the Secretary).

5 “(iv) SEVERELY DISABLED CHIL-
6 DREN.—An individual under 6 years of age
7 who—

8 “(I) has a severe disability or
9 chronic medical condition,

10 “(II) but for receiving services
11 under this section, would require insti-
12 tutionalization in a hospital, nursing
13 facility, or intermediate care facility
14 for the mentally retarded, and

15 “(III) is expected to have such
16 disability or condition and require
17 such services over a period of at least
18 100 days.

19 “(B) ACTIVITY OF DAILY LIVING.—The
20 term ‘activity of daily living’ means any of the
21 following:

22 “(i) Eating.

23 “(ii) Toileting.

24 “(iii) Dressing.

25 “(iv) Bathing.

1 “(v) Transferring.

2 “(vi) Continence.

3 “(4) QUALIFIED CASE MANAGER.—The term
4 ‘qualified case manager’ means a person who—

5 “(A) provides case management services to
6 an eligible individual with disabilities;

7 “(B) is not a relative of such individual;

8 “(C) has experience in—

9 “(i) assessing individuals’ functional
10 and cognitive impairment;

11 “(ii) establishing, periodically review-
12 ing, and revising individual care plans or
13 has been trained in such activities; and

14 “(iii) the provision of case manage-
15 ment services to individuals such as eligible
16 individuals with disabilities; and

17 “(D) meets such other standards estab-
18 lished by the Secretary or the State which may
19 include standards which assure—

20 “(i) the quality of case management
21 services; and

22 “(ii) that individuals receiving case
23 management services are not at risk of fi-
24 nancial exploitation.

1 “(5) QUALIFIED PROVIDER.—The term ‘qualified
2 provider’ means a provider who is licensed
3 under State law or who meets other criteria as the
4 Secretary or State may specify.

5 “(6) RELATIVE DEFINED.—The term ‘relative’
6 means an individual bearing a relationship to an-
7 other individual who is described in paragraphs (1)
8 through (8) of section 152(a) of the Internal Reve-
9 nue Code of 1986.”.

10 (c) PAYMENT TO STATES.—

11 (1) IN GENERAL.—Section 1903(a) (42 U.S.C.
12 1396b(a)), as amended by section 403(b), is
13 amended—

14 (A) by striking “plus” at the end of para-
15 graph (7);

16 (B) by striking the period at the end of
17 paragraph (8) and inserting “; plus”; and

18 (C) by adding at the end the following new
19 paragraph:

20 “(9) an amount equal to the Federal home and
21 community-based services matching percentage (as
22 defined in section 1905(t)) of the total amount ex-
23 pended during such quarter for covered home and
24 community-based services furnished under section
25 1931.”.

1 (2) FEDERAL HOME AND COMMUNITY-BASED
2 SERVICES MATCHING PERCENTAGE.—Section 1905
3 (42 U.S.C. 1396d) is amended by adding at the end
4 the following new subsection:

5 “(t) The term ‘Federal home and community-based
6 services matching percentage’ means, with respect to a
7 State, the State’s Federal medical assistance percentage
8 (as defined in subsection (b)) increased by 20 percentage
9 points, except that the Federal home and community-
10 based services matching percentage shall in no case be less
11 than 75 percent or more than 88 percent.”.

12 (d) EFFECTIVE DATE.—The amendments made by
13 this section shall be effective with respect to calendar
14 quarters beginning on or after January 1, 1997.

15 **SEC. 407. REPORTS BY THE SECRETARY ON CERTAIN IS-**
16 **SUES RELATING TO LONG-TERM CARE.**

17 The Secretary shall submit a report to Congress an-
18 nually on—

19 (1) the effectiveness of State programs to fur-
20 nish home and community-based services to individ-
21 uals with disabilities under section 1931 of the So-
22 cial Security Act; and

23 (2) the growth and development of the market
24 for long-term care insurance.

1 SEC. 408. REPORT BY THE SECRETARY ON LONG-TERM
2 CARE SERVICES FOR CHRONICALLY ILL INDIVIDUALS.

4 (a) IN GENERAL.—Not later than July 1, 1997, the
5 Secretary shall submit a report to Congress on the fea-
6 sibility and cost of including long-term care services for
7 chronically ill individuals as a benefit under a standard
8 benefit package to be offered under a reformed health care
9 system.

10 (b) CHRONICALLY ILL INDIVIDUAL.—The term
11 “chronically ill individual” means an individual with a se-
12 rious and persistent chronic health condition.

13 SEC. 409. CHRONIC CARE COMMISSION.

14 (a) ESTABLISHMENT.—There is established a com-
15 mission to be known as the Chronic Care Commission
16 (hereafter referred to in this section as the “Commis-
17 sion”).

18 (b) MEMBERSHIP.—

19 (1) IN GENERAL.—The Commission shall con-
20 sist of—

21 (A) the Secretary of Health and Human
22 Services (hereafter referred to in this section as
23 the “Secretary”); and

24 (B) 10 other members to be appointed by
25 the President, in consultation with the Majority
26 and Minority Leaders of the House of Rep-

1 representatives and the Senate, not later than 30
2 days after the date of the enactment of this sec-
3 tion.

4 (2) CHAIR.—The Secretary shall serve as the
5 Chair of the Commission.

6 (3) EXPERTISE.—The members of the Commis-
7 sion appointed under paragraph (1)(B) shall include
8 representatives of—

- 9 (A) chronically ill individuals;
- 10 (B) health care providers who furnish—
 - 11 (i) primary care services;
 - 12 (ii) acute care services;
 - 13 (iii) institutional services; and
 - 14 (iv) home and community-based serv-
 - 15 ices;
- 16 (C) the health insurance industry; and
- 17 (D) Federal and State health programs.

18 (4) TERMS.—Members of the Commission shall
19 be appointed for the life of the Commission. A va-
20 cancy on the Commission shall be filled in the man-
21 ner in which the original appointment was made and
22 shall be subject to any conditions which applied with
23 respect to the original appointment.

24 (c) DUTIES.—Not later than July 1, 1997, the Com-
25 mission shall submit to Congress legislative recommenda-

1 tions to simplify and improve chronic care services fur-
2 nished to chronically ill individuals. Such recommenda-
3 tions shall—

4 (1) encourage health care providers to establish
5 community based networks which furnish chronic
6 care services to chronically ill individuals;

7 (2) result in a reduction in the growth of the
8 cumulative costs of furnishing chronic care services
9 to such individuals across time and setting;

10 (3) outline chronic care service delivery reform
11 which simplifies systems for administration, financ-
12 ing, and delivery of such services to such individuals;

13 (4) identify barriers to integration of chronic
14 care services as established by existing legislative,
15 regulatory, and administrative practices; and

16 (5) provide for a private sector, community-
17 based approach to furnishing chronic care services to
18 such individuals.

19 (d) CONSULTATION WITH CERTAIN ENTITIES.—In
20 developing its legislative recommendations under sub-
21 section (c), the Commission shall consult with qualified en-
22 tities participating in the demonstration projects on acute
23 and long-term care integration conducted by the Secretary
24 under section 410.

25 (e) MEETINGS.—

1 (1) IN GENERAL.—Except as provided in para-
2 graph (2), the Commission shall meet at the call of
3 the Chair.

4 (2) INITIAL MEETING.—Not later than 30 days
5 after the date on which all members of the Commis-
6 sion have been appointed, the Commission shall hold
7 its first meeting.

8 (3) QUORUM.—A majority of the members of
9 the Commission shall constitute a quorum, but a
10 lesser number of members may hold hearings.

11 (f) POWER OF THE COMMISSION TO HOLD HEAR-
12 INGS.—The Commission may hold such hearings, sit and
13 act at such times and places, take such testimony, and
14 receive such evidence as the Commission considers advis-
15 able to carry out the purposes of this section.

16 (g) COMMISSION PERSONNEL MATTERS.—

17 (1) COMPENSATION OF MEMBERS.—Each mem-
18 ber of the Commission who is not an officer or em-
19 ployee of the Federal Government shall be com-
20 pensated at a rate equal to the daily equivalent of
21 the annual rate of basic pay prescribed for level IV
22 of the Executive Schedule under section 5315 of title
23 5, United States Code, for each day (including travel
24 time) during which such member is engaged in the
25 performance of the duties of the Commission. All

1 members of the Commission who are officers or em-
2 ployees of the United States shall serve without com-
3 pensation in addition to that received for their serv-
4 ices as officers or employees of the United States.

5 (2) TRAVEL EXPENSES.—The members of the
6 Commission shall be allowed travel expenses, includ-
7 ing per diem in lieu of subsistence, at rates author-
8 ized for employees of agencies under subchapter I of
9 chapter 57 of title 5, United States Code, while
10 away from their homes or regular places of business
11 in the performance of services for the Commission.

12 (3) DETAIL OF GOVERNMENT EMPLOYEES.—
13 Any Federal Government employee may be detailed
14 to the Commission without reimbursement, and such
15 detail shall be without interruption or loss of civil
16 service status or privilege.

17 (h) TERMINATION OF THE COMMISSION.—The Com-
18 mission shall terminate 90 days after the date on which
19 the Commission submits its legislative recommendations
20 under subsection (c).

21 (i) DEFINITIONS.—For purposes of this section—

22 (1) CHRONIC CARE SERVICES.—The term
23 “chronic care services” means a full range of indi-
24 vidualized services for chronically ill individuals, in-
25 cluding primary care, hospital, nursing home, and

1 community-based services which satisfy the func-
2 tional, psychological, environmental, social, and med-
3 ical needs of such individuals and which enable such
4 individuals to optimize functional independence and
5 well being.

6 (2) CHRONICALLY ILL INDIVIDUAL.—The term
7 “chronically ill individual” means an individual with
8 a serious and persistent chronic health condition.

9 (j) AUTHORIZATION OF APPROPRIATIONS.—

10 (1) IN GENERAL.—There are authorized to be
11 appropriated such sums as may be necessary to
12 carry out the purposes of this section.

13 (2) AVAILABILITY.—Any sums appropriated
14 under the authorization contained in this subsection
15 shall remain available, without fiscal year limitation,
16 until expended.

17 **SEC. 410. DEMONSTRATION PROJECTS ON ACUTE AND**
18 **LONG-TERM CARE INTEGRATION.**

19 (a) PROJECTS AUTHORIZED.—Not later than Janu-
20 ary 1, 1996, the Secretary of Health and Human Services
21 (hereafter referred to in this section as the “Secretary”)
22 shall begin to conduct demonstration projects under which
23 qualified entities test the effectiveness of various ap-
24 proaches to financing and providing integrated acute and
25 long-term care services to chronically ill individuals (as de-

1 fined in section 408(h)(2)) and individuals with disabilities
2 (as defined in section 1931(h)(3) of the Social Security
3 Act).

4 (b) DEMONSTRATION PROJECTS DESCRIBED.—Dem-
5 onstration projects conducted under this section shall es-
6 tablish an approach to financing and providing integrated
7 acute and long-term care services to chronically ill individ-
8 uals and individuals with disabilities which—

9 (1) improves quality through—
10 (A) management of ongoing chronic condi-
11 tions rather than treatment of episodes;

12 (B) increasing the competency of individ-
13 uals furnishing care; and
14 (C) providing care which produces the best
15 outcomes;

16 (2) increases the satisfaction of individuals re-
17 ceiving care by—

18 (A) offering unified care over the duration
19 of an individual's condition;

20 (B) simplifying access and transfer proce-
21 dures; and

22 (C) permitting such individuals to partici-
23 pate in decision making regarding their care;
24 and

25 (3) contains cumulative costs by—

- 1 (A) managing costs as an individual's con-
2 dition progresses;
3 (B) allowing providers of care to have con-
4 trol and flexibility; and
5 (C) financing and fostering prevention and
6 functional independence.

7 (c) APPLICATIONS.—Each qualified entity desiring to
8 conduct a demonstration project under this section shall
9 submit an application at such time as the Secretary deter-
10 mines appropriate containing—

11 (1) assurances that the acute and long-term
12 care services furnished by the entity to chronically ill
13 individuals and individuals with disabilities under
14 the demonstration project will cost less than if such
15 services were furnished to such individuals other
16 than under the demonstration project; and
17 (2) such other information as the Secretary de-
18 termines appropriate.

19 (d) NUMBER AND DURATION OF DEMONSTRATION
20 PROJECTS.—

21 (1) NUMBER.—The Secretary shall authorize
22 not more than 7 demonstration projects under this
23 section.

1 (2) DURATION.—A demonstration project under
2 this section shall be conducted for a period of 7
3 years.

4 (e) EVALUATION AND REPORTS.—The Secretary
5 shall evaluate the demonstration projects conducted under
6 this section and shall submit to Congress—

7 (1) an interim report, not later than 3 years
8 after the date on which the first demonstration
9 project begins, describing the status of the dem-
10 onstration projects; and

11 (2) a final report, not later than 1 year after
12 the last of the demonstration projects is completed,
13 evaluating the effectiveness of the demonstration
14 projects.

15 (f) DEFINITION OF QUALIFIED ENTITY.—For pur-
16 poses of this section, the term “qualified entity” means
17 an entity meeting the eligibility criteria established by the
18 Secretary.

19 (g) AUTHORIZATION OF APPROPRIATIONS.—

20 (1) IN GENERAL.—There are authorized to be
21 appropriated such sums as may be necessary to
22 carry out the purposes of this section.

23 (2) AVAILABILITY.—Any sums appropriated
24 under the authorization contained in this subsection

1 shall remain available, without fiscal year limitation,
2 until expended.

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